



**Senate Health Care Reform Bill:  
The Patient Protection and Affordable Care Act  
Assessing the Impact for People with Mental Illnesses**

On November 18, 2009, Senate Democratic leaders unveiled the Patient Protection and Affordable Care Act (H.R. 3590); a bill to reform America's health care system. Earlier bills passed by the Senate Health, Education, Labor and Pensions Committee and Senate Finance Committee were merged to create a single bill that fulfills the goals of expanding access to quality, affordable health care, reducing health care costs, improving the quality of care and emphasizing prevention. The same day, the Congressional Budget Office released estimates indicating that H.R. 3590 would extend insurance coverage to 31 million Americans who are currently uninsured and reduce the federal budget deficit by \$130 billion within the first 10 years after implementation. The Senate overcame a threatened filibuster and voted 60-39 to open debate on November 21st. Debate on the bill concluded, and the Senate, in its first Christmas Eve vote in over 100 years, passed this historic bill with a final, party-line vote of 60-39.

*Overview*

The bill includes the following reforms:

- Insurance reforms that end discriminatory practices too often experienced by individuals with mental illnesses, such as elimination of: lifetime or annual dollar limits, exclusions for preexisting conditions and rates based on health status, gender or occupation;
- State Health Insurance Exchanges that would serve as a marketplace to assist uninsured individuals and small employers in purchasing private health plans;
- Standardized benefit packages among the plans offered through the Exchanges that would make it easier to compare and select coverage based on cost and quality information;
- A minimum benefit package that includes mental health and addiction services;
- Tax credits and cost-sharing reductions to assist low-income households with the cost of purchasing insurance;

- Out-of-pocket spending limits, restricting the amount an individual is required to contribute towards the cost of care, which would help ease the burden on people who have frequent needs for health care services, drugs and supplies;
- A requirement that individuals obtain coverage or pay a penalty; and
- Expansion of Medicaid to children and pregnant women with incomes at or below 133 percent of the federal poverty level and limited Medicaid coverage to childless adults with incomes at or below 133 percent of poverty.

## **Insurance Market Reforms**

To end discriminatory practices and make coverage more affordable, the bill includes insurance market reforms that would help individuals with mental illnesses acquire insurance at a fairer price. The Senate bill proposes to reform the insurance market by:

- Requiring insurers to offer and renew insurance coverage for all who apply (guaranteed issue and renewal);
- Prohibiting the denial of coverage on the basis of pre-existing conditions;
- Prohibiting health insurers from taking away health coverage;
- Specifying that premium rates in the individual and small group market can only vary on the basis of tobacco use, age and family composition at ratios ranging from 1to 3:1, and on the basis of state-defined geographic rating areas;
- Allowing dependent children to remain on their parents' health policies until the age of 26; and
- Providing immediate assistance to individuals with pre-existing conditions through the establishment of high-risk pools.

Effective for plan years beginning six months after enactment, the Senate bill would prohibit insurers from denying or failing to renew coverage on the basis of health status, medical conditions, including mental illnesses, disability and a number of other circumstances that currently allow insurers to discriminate against many people.

These provisions would make it easier for people with mental illnesses to purchase affordable, quality insurance. Currently, those who purchase insurance through the individual or small group market are often subjected to lifetime and annual limits on mental health treatment, leaving people with mental illnesses burdened with substantial debt if they experience ongoing health and mental health problems and persistent treatment needs. They have not been afforded the financial protection that insurance was intended to provide.

The bill also contains a provision that would allow dependent children to remain on their parents' health policies until the age of 26. This would take effect for plan years beginning six months after enactment of the bill. Youth transitioning to adulthood have a difficult time accessing and maintaining coverage, and those with emotional and behavioral disturbances are at greater risk for being uninsured. They may be ineligible for Medicaid coverage because they

do not meet the standards for disability, even though they have significant functional impairments, or because they are living with parents whose income disqualifies them. They are likely to be unemployed or employed in part-time jobs without benefits. Offering the option to extend coverage to 26 would help to lower the uninsurance rate in the 18- 26 age cohort and help more vulnerable youth.

Because these reforms would not take effect immediately, the Senate bill would offer early assistance to uninsured individuals who have been denied coverage based upon pre-existing conditions by allowing them to enroll in a high-risk pool within a year of the legislation's enactment. This provision is particularly important for individuals with mental illnesses, who often fail to qualify for individual or small-group insurance because their disorder constitutes a pre-existing condition. The bill also requires the Secretary of Health and Human Services to establish by July 1, 2010 a website that would allow consumers to identify affordable health insurance coverage options in their state, including Medicaid or Medicare, SCHIP and high-risk pools. These measures would ensure that many individuals with mental health disorders need not wait to benefit from the insurance market reforms scheduled to go into effect several years into the future.

Individuals who currently have coverage would be able to keep their plans if desired.

#### *Requirement to Purchase Insurance*

Starting in 2013, all American citizens and legal residents would be required to purchase coverage through the individual market, through public programs such as Medicare and Medicaid, or through their employer, unless they are eligible for an exemption due to hardship or religious reasons, are Native American, or are at or below 100% of the Federal Poverty Level. Individuals who fail to purchase insurance would have to pay a phased-in penalty tax ultimately resulting in a fee of \$750 per individual or up to \$2,250 for a family. The bill does not explicitly mandate employers to offer health insurance coverage, however any employer with more than 50 full-time employees that does not offer coverage and has at least one full-time employee receiving the premium assistance tax credit would be subject to a fee of \$750 per full-time employee. Employers that do offer insurance and require a waiting period before employees may enroll in the plan would be subject to a fee.

#### *State Health Insurance Exchanges*

In order to facilitate easy comparison and purchase of health insurance plans, individual and small business state-based governmental or nonprofit "exchanges" would be established effective January 1, 2014. The bill allows states to merge individual and small business exchanges into one state exchange, provided that the state exchange has adequate resources to assist both individuals and qualified small employers. Large employers would be eligible to purchase coverage through the exchange beginning in 2017. States would receive federal support to establish exchanges until January 1, 2015, at which time state exchanges should be self-sustaining. Regional or other Interstate exchanges may be established if states in which the

regional exchange operates permit operation and if it is approved by the Secretary of Health & Human Services.

Under the Senate bill, the Secretary of Health & Human Services would issue regulations on marketing, network adequacy, accreditation, consumer information, outreach and enrollment and public information for the exchanges. Exchanges would be responsible for ensuring that health plans offering coverage meet standards established by the Secretary. They would qualify health plans for participation, determine eligibility of individuals and businesses, administer subsidies and facilitate consumer assistance.

Individuals may enroll in any qualified health plan made available to them. Employers and individuals are under no obligation to purchase insurance through the exchange and can still purchase a health plan offered outside of the exchange. However, the bill compels employers that offer coverage and make a contribution to employee's premium to provide "free choice vouchers" to qualified employees for the purchase of qualified health plans through Exchanges. Vouchers must be equal to the contribution that the employer would have made to its own plan, and an employee qualifies if their required contribution under the employer's plan would cost between 8 and 9.8 percent of their income. Additionally, the bill indicates that plans made available to members of Congress and their staff must be offered through an exchange. In place of a single state exchange, the bill also allows for interstate Health Care Choice Compacts between two or more states to allow the purchase of individual health insurance across state lines. However, insurers must still be licensed in each state and must meet any consumer protection mandates of the state in which a covered individual resides.

#### *Public Option*

The amended bill does not offer the federal government an opportunity to create a public option. Instead, it allows for the establishment of Nonprofit Consumer Co-operatives and multi-state insurance plans.

#### *Nonprofit Consumer Co-operatives*

In addition to the private insurance plans and the public option, H.R. 3590 would create the option for consumer operated nonprofit cooperatives that would also offer insurance. These entities would be new, nonprofit, member-administered health insurance companies that serve individuals in one or more states. The bill would provide \$6 billion in start-up support to organizations wishing to establish these not-for-profit, cooperative health plans to compete with private insurers..

#### *Multi-state Insurance Plans*

The bill requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans through Exchanges in each State, similar to the Federal Employees Health Benefits Program. Such plans would be required to meet

minimum standards and regulations established for qualified health plans, and States would be allowed to offer additional services, provided that States assume the resulting additional costs.

### *State Option for a Basic Plan*

The Senate bill also gives states the opportunity to establish a federally funded, non-Medicaid state plan for people with incomes above the Medicaid eligibility level, but below 200 percent of the Federal Poverty Level in lieu of offering these individuals coverage through the exchange. These state plans would be funded by the federal government and enable states to offer health care coverage through contracts with private health systems. These state plans would be required to meet certain benefit standards and premium assistance would be made available for the eligible population.

### *State Innovation Waiver*

The Senate proposal encourages state innovation by allowing states to opt out of certain provisions in the proposed legislation through a waiver process. States may apply to the Secretary of Health and Human Services for waivers (permission to be exempt from certain aspects of the law) to provide health care coverage that is at least as ample as that required for the exchanges. In order to be eligible, states must show that the proposed state plan would assure all residents of access to quality, affordable insurance plans that are at least as comprehensive as the plans offered through an exchange.

## **Making Coverage Affordable**

### *Benefits*

Four benefit categories, Bronze, Silver, Gold and Platinum, would be offered to consumers through each state exchange. Each plan would have a different value and different out-of-pocket costs with an upper limit on out-of-pocket. Small employers purchasing coverage through the exchange would be required to offer a plan with a deductible not exceeding \$2,000 for an individual or \$4,000 for a family.

**All exchange plans would be required to offer a minimum benefit package, which must cover mental health and addiction services and those benefits must meet the standards for parity in both federal and state law.** There would be no cost-sharing for preventive services.

The details of the benefit package would be defined and updated by the Secretary of Health and Human Services annually through a transparent process that permits public comment and input.

A “young invincible” policy is also required under the Senate bill, available to those 30 years old or younger and to those who would otherwise qualify for the exemption from the individual requirement (see below), offering only catastrophic coverage.

### *Tax Credits for Premium Costs*

Beginning after December 21, 2013, tax credits for meeting the costs of insurance premiums and reduced cost-sharing requirements would be made available to lower-income individuals to assist them in meeting the costs of purchasing health insurance through a state exchange. Individuals would be eligible for the credit if their income is up to 400% of the Federal Poverty Level; income levels would be verified by information received from the IRS from the prior tax year. The bill also reduces cost-sharing for eligible individuals by lowering the limit on out-of-pocket costs that individuals would be responsible for paying for care. Additionally, the bill would provide a tax credit for qualified small employers and nonprofit companies for contributions to purchase health insurance for their employees.

### **Protecting Consumers**

The bill includes provisions to ensure that individuals and small businesses purchasing through the state exchanges have unbiased information, decision support and enrollment assistance. The bill also includes provisions to guard against fraud, abuse and unethical or unlawful practices.

### *Consumer Information*

Web-based information systems would be established by the exchanges to allow consumers to easily identify and compare affordable health insurance coverage options, and health plans would be required to provide standardized information so that the marketplace is fair to consumers, providers and plans. Insurers would be required to compile and provide to plan enrollees a summary of benefits and coverage, so as to allow consumers to accurately understand their plan's coverage and benefits. Insurers must abide by standards established by the Secretary of Health and Human Services when developing such summaries, including presenting plan information in language that is understandable by the average enrollee, ensuring that specific topics such as cost-sharing provisions or a description of benefits are included in plan information materials, requiring appropriate definitions of insurance terms, and including insurer contact information. Insurers not in compliance would face a fine of up to \$1,000 for each failure to comply. The Senate bill also includes provisions requiring hospitals to establish and make public a list of standard charges for items and services.

### *Direct Consumer Assistance*

States would receive federal support to contract with private and public entities to act as navigators to assist those seeking to obtain quality and affordable coverage through exchanges. The navigators would conduct public education activities, distribute information about enrollment and premium credits, and provide enrollment assistance.

The bill also provides for grants to enable states to establish, expand and support offices of health insurance consumer assistance, or health insurance ombudsman programs. Such offices

would assist consumers with enrollment, resolving problems with obtaining premium tax credits and filing complaints and appeals, as well as educating health insurance consumers on their rights and responsibilities and collecting and monitoring problems encountered by consumers.

### *Value*

The Senate bill has provisions designed to protect consumers from unreasonable costs, such as allowing the Secretary to review annually unreasonable increases in premiums for health insurance coverage.

### **Medicaid**

The bill proposes the following changes to Medicaid:

- Expand Medicaid eligibility to cover adults based on income (covering all those with incomes at or below 133% of poverty);
- Limit the covered services for many of these newly eligible individuals so that they would not receive the same benefits as other Medicaid-eligible individuals;
- Provide a significantly higher federal match for services furnished to the newly eligible individuals;
- Improve the home- and community-based services of Medicaid (Section 1915(i) and Section 1915(c)), expanding access and services covered;
- Emphasizes prevention;
- Improve prescription drug coverage;
- Improve services for individuals who are dually eligible for Medicaid and Medicare; and
- Include provisions designed to improve the quality of Medicaid services.

### *Eligibility*

Effective in 2014, Medicaid eligibility would be expanded to cover all individuals with incomes at or below 133% of poverty (\$30,000 a year for a family of four, or \$14,400 for an individual in 2009). States also have the option to begin this coverage (or to phase it in) starting in 2011. Unfortunately, however, not all of the newly eligible individuals would have coverage for the full array of Medicaid services.

States are also given the option to cover individuals over 133% of poverty, including childless adults, but must first cover all those with lower incomes. This expansion means that, for the first time, non-elderly, non-pregnant adults without children would be eligible for Medicaid based on their income – they would not have to meet some additional standard (such as being on Supplemental Security Income benefits). Currently, many individuals with serious mental illnesses are not entitled to Medicaid because they do not receive federal disability benefits or have dependent children. Allowing adults to qualify solely on economic factors is a long

overdue change that would significantly improve access to Medicaid. Without this coverage, a significant number of uninsured adults with serious mental illnesses have been forced to go without care, resulting in health and mental health emergencies. Extending Medicaid coverage based on income has the potential to increase access to mental health treatment and to expand Medicaid revenue for the public mental health system.

Those newly eligible childless adults who have incomes at or below 133% of the poverty level would, however, be given limited benefits that can be designed by the state but must comport with the rules for benchmark Medicaid plans set under the Deficit Reduction Act (DRA) of 2005, which, in turn, was based on the coverage under the SCHIP program. The total value of these benchmark plans is constrained by the legislation to make it equivalent to certain private insurance plans. Under the Senate bill, the benchmark package must provide minimum essential coverage, including mental health services which must be covered at parity with other medical/surgical care. However, the extent of coverage can be more limited than traditional Medicaid — for example; all physician services could be limited to a specific number per year. In addition, the range of services would not be as extensive as under regular Medicaid. Inpatient and outpatient services and medications are likely to be included, but rehabilitation services and targeted case management may not be covered.

Certain groups in this income range are exempted from this benchmark coverage provision, including: pregnant women, disabled individuals, dual Medicare-Medicaid individuals, individuals eligible only because they are in an institution, medically frail and special medical needs individuals, individuals who qualify for long-term care services, children in foster care and children receiving foster care or adoption assistance and parents receiving welfare benefits.

Another provision in the bill extends Medicaid coverage for former foster care children up to age 25.

### *Federal Share*

The federal government would pay 100% of the costs of covering newly eligible individuals under Medicaid until 2017, at which time states would start to contribute to the cost (rates vary by state), but the federal percentage would be considerably more than under current law. States are required to maintain eligibility standards until the state exchange is fully operational, and must maintain children's coverage until 2019.

### *Home- and Community-Based Services*

Access to home- and community-based services (HCBS) is improved for low-income individuals in need of long-term community care. There are incentives for states to offer HCBS as alternatives to institutional care for individuals with disabilities who require long-term care services and supports.



The state plan option to cover home- and community-based services (Section 1915(i) of the law) is amended to raise the income level for eligibility so it is the same as under home- and community-based waivers (i.e. 300% of the SSI level in the state). The range of services that can be furnished under Section 1915(i) is also expanded so as to be the same as the services allowed under home- and community based waivers. The provision in current law that allowed states to set a limit on the number of individuals who could receive Section 1915(i) services has been repealed. Finally, states may target this state-plan service to a specific population, such as people with mental illnesses. **The effect of this set of changes would be to make the Section 1915(i) state plan option far more helpful for persons with serious mental illnesses.**

A broad range of home- and community-based services can now be furnished, and these services can be specific to persons with mental illnesses. Income eligibility is now parallel to income eligibility for home- and community-based waivers and all individuals who meet the needs-based criteria in the law would be eligible for the services. To date, very few states have shown an interest in Section 1915(i) but it is hoped that, with these changes, more states would adopt this important option. The bill would also create a new section of the Social Security Act, Section 1915(k) authorizing a state plan option to provide home- and community-based attendant care services and supports to individuals with incomes at or below 150% of poverty who, without such services, would require institutional care.

Additionally, the bill as amended includes a new policy that provides financial incentives for States who shift Medicaid beneficiaries out of nursing homes and into home and community based services (HCBS). The provision extends FMAP increases to States to account for differences in spending between nursing homes and HCBS.

### *Prescription Drug Coverage*

The bill includes amendments that are designed to make prescription drugs cheaper for Medicaid programs, saving resources for the states. In addition, certain drugs that have been excluded from

Medicaid coverage would now be eligible for a federal Medicaid match, including smoking cessation medications, barbiturates and benzodiazepines. **All of these medications are important for people with mental illnesses.**

### *Individuals with Dual Eligibility*

The bill establishes an Office of Coordination for Dual Eligible Beneficiaries to be responsible for leading efforts to align Medicare and Medicaid policies for those who are entitled to Medicare Part A and/or Part B and are also eligible for some form of Medicaid benefit. The proposal also makes prescriptions more affordable for dual eligibles who are receiving home- and community-based services by making their prescription co-payments equal to those of dual eligibles who reside in long-term care facilities.

### *Enrollment*

The bill attempts to improve access and enrollment in Medicaid for eligible individuals by requiring state Medicaid programs to develop an enrollment website and further streamline the application process. The bill also requires the Secretary of HHS to develop and provide to states a single streamlined application form for Medicaid, SCHIP and tax credit subsidies. This would be a simplified form than can be filed online, in person, or by mail or telephone. The enrollment process for Medicaid coverage is protracted and complex, which often deters eligible individuals from applying. This process is particularly difficult for individuals with serious mental illnesses, whose symptoms may impair thought and functioning. Streamlining the enrollment process would decrease barriers to enrollment and effectively encourage individuals with mental illnesses to apply.

### *Therapeutic Foster Care*

The Finance Committee had included language in its version of the bill to clarify that therapeutic foster care is a covered Medicaid service and one that must be defined. The combined Senate bill does not include this provision. Therapeutic foster care (TFC), a cost-effective and evidence-based practice, provides an intensive therapeutic living environment for a child with a behavior disorder who requires out-of-home care. TFC offers a structure and supervision by a specially trained family for one or two children at a time, and is a vital service for children who would otherwise be placed in restrictive residential programs. The amendment would have provided guidance to states that cover therapeutic foster care and its elimination is a significant loss.

### *Prevention*

The bill requires states to cover tobacco-cessation services for pregnant women with no cost-sharing requirements. A new program of support, education and research for postpartum depression is authorized. Grants are also authorized under Title V of the Social Security Act to provide services to individuals with a postpartum condition and their families, with \$3 million to be available for such grants in FY 2010.

### *Medicaid Quality Measures and Improvements*

The bill instructs the Secretary of Health and Human Services to develop a recommended core set of health quality measures for adults who are eligible for Medicaid, similar to an existing requirement regarding child health quality measures. After the core measures are issued, the Secretary is to establish a Medicaid Quality Measurement program to develop, test and validate emerging and innovative evidence-based measures for Medicaid. States would report on these measures with respect to Medicaid-eligible adults.

## *Health Care Homes*

The bill establishes a new Medicaid state plan option that would allow beneficiaries with at least two chronic conditions, those with one chronic condition who are at risk of developing another chronic condition or those with a serious and persistent mental health condition to designate a provider as their “health home.” These health homes would be required to meet certain standards and provide specific services, including comprehensive care management, care coordination, health promotion, transition services from inpatient to other settings, patient and family support and referrals to appropriate community services.

States would be required to consult and coordinate with the Substance Abuse and Mental Health

Services Administration in addressing issues regarding the prevention and treatment of mental illnesses and substance abuse among eligible individuals with chronic conditions. Additionally, **community mental health centers are listed among the eligible entities that can be designated as a health care home. Mental health professionals may also participate as part of any health care home clinical team.**

Collaborative care models that entrust one entity with the comprehensive management and coordination of an individual’s care have been found effective in treating mental illnesses. Such systems offer an opportunity for prevention and early intervention and can form a basis for improving quality and making care more affordable. In a collaborative care model, primary care and behavioral health professionals can be co-located and offer easy access to mental health treatment for those with other serious or chronic illnesses whose recovery is impaired by a co-occurring mental health disorder. For more complex cases, health homes can provide improved referral and linkage with community mental health specialty care. Community behavioral health centers, which often serve as the only source of care for individuals with severe mental illnesses, can provide coordinated primary care services in familiar, comfortable locations.

## *Medicaid Emergency Psychiatric Care Demonstration Project*

The Senate bill provides \$75 million for a three-year demonstration project that would fund up to eight states to reimburse non-governmental freestanding psychiatric hospitals under Medicaid for emergency psychiatric treatment. Currently, psychiatric hospitals are required to provide such emergency services under the Emergency Medical Treatment and Active Labor Act, but they are prohibited from receiving federal matching payments under Medicaid because of rules that preclude Institutions for Mental Disease (IMDs) from Medicaid coverage.

## *Comparison of House and Senate Bills*

The scope of Medicaid reforms proposed in the Senate bill is narrower than in the House health reform bill. The House bill extends full, comprehensive Medicaid coverage to individuals with incomes up to 150% of poverty, while the Senate bill extends Medicaid only to those up to

133% of poverty, and for those whose income falls between 100% and 133% of poverty, only a minimum benchmark plan benefit would be provided.

The House bill also includes a provision that clarifies that therapeutic foster care is a covered service for children. There is no such language in the Senate version.

### **State Children's Health Insurance Program**

Initially, states would receive an enhanced federal match for services to children who qualify under the State Children's Health Insurance Program (SCHIP). States would be required to maintain their current CHIP eligibility level until December 31, 2019, but would be free to expand current income eligibility levels to include more children at any time. Beginning in 2016, states would receive a higher matching rate to help finance the continuation of their CHIP programs. If SCHIP federal allotments are insufficient to cover all children who would be eligible under SCHIP, the state must establish procedures to ensure that such children are provided coverage through the Exchange.

### **Medicare**

The bill includes a number of changes to Medicare, including:

- Assisting Medicare beneficiaries who experience the coverage gap, or "donut hole," that plagues the Medicare Part D program;
- Requiring coverage under Part D of all drugs in certain classes, including certain mental health medications; and
- Adjustments to the low-income subsidies for Part D coverage.
- Eliminating cost-sharing for preventive services.

#### *Medicare Part D—Prescription Drug Coverage*

The bill improves the Part D prescription drug program by providing a discount program for beneficiaries who have spent enough on prescriptions to reach the "donut hole," or the gap in coverage that occurs when an individual has reached an initial prescription drug coverage limit. Under Part D, coverage ceases once individuals drug costs reach a certain level, and does not pick up again until the individual has paid out-of-pocket for all drug costs up to a high level of spending. This gap is commonly called the donut hole. The discount program would allow individuals with low to moderate incomes to receive a 50% discount on the price of brand-name drugs while they are in this coverage gap. The bill also narrows the donut hole, raising by \$500 the amount of drug spending that is initially covered. The bill requires that all drugs in certain classes must be included in Part D drug formularies. Two of those classes of drugs are antidepressants and antipsychotics. This language codifies existing administrative requirements.

The bill makes several adjustments to the rules governing low-income subsidies, all of which would benefit low-income people and make their medications more affordable. Because

Medicare already has relatively high-cost sharing requirements and no overall limits on out-of-pocket spending, provisions that lessen the financial burdens, like addressing the coverage gap in Part D and increasing low-income subsidies, are important to ensure that beneficiaries with mental illnesses are not forced to choose between filling vital prescriptions, seeing the doctor and paying for other necessities.

## **Maternal and Child Health Program, Title V**

### *Early Childhood Visits*

The bill adds a new section to Title V of the Social Security Act that would require states, as a condition for receiving the Maternal and Child Health block grant, to conduct needs assessments to determine which communities are most at risk for poor maternal and child health and have few quality home visitation programs. The assessment would also evaluate the state's capacity to provide necessary and appropriate services to communities at risk. A new state grant program would be established for early childhood home visitation. Grantees would be required to meet certain performance and quality standards and outcomes. The bill authorizes \$400 million for these activities by FY 2014.

This provision would encourage one of the most promising areas of mental health prevention and early intervention: improving the social and emotional development of very young children and identifying mental health problems in infants and toddlers. Approximately 20 percent of children will develop a mental health disorder that leads to functional impairments, and abused and neglected infants demonstrate a number of troubling symptoms such as post-traumatic stress, cognitive dysfunction, greater aggressiveness and more fear in response to angry interactions between adults. Mental disorders are increasingly being identified in younger and younger children. Home visiting programs have demonstrated positive results by lessening the effects of maternal depression and child maltreatment, by improving the mother-infant relationships and by increasing infant scores on cognitive tests and measures of social functioning.

## **Quality and Transparency**

The bill encourages improved health care quality through a variety of initiatives, including promoting payment mechanisms that link payment to outcomes and reward doctors and providers for achieving good patient outcomes. It would also allow value-based payments to hospitals that meet performance standards, and encourages development of innovative patient care models that create collaborative decision-making processes and advance the goal of quality care. Additional resources would be made available to the Department of Health and Human Services (HHS) to strengthen quality assurance processes. Additionally, the amended bill requires the Secretary of HHS to develop and report publicly patient outcomes measures. A national quality improvement strategy would be developed, as well as a federal interagency working group on health care quality.

### *National Strategy for Quality Improvement*

Health outcomes, as well as quality initiatives to improve them, vary widely across the country. The Senate bill calls for the development of a national strategy that aims to address gaps in quality, reduce geographic variations, enhance the use of data to improve quality, and reduce health disparities while improving the delivery of health care services, patient health outcomes, and population health.

Half of people with serious mental illness do not receive any treatment, and another 25 percent receive treatment that is not consistent with evidence-based guidelines. Outmoded mental health practices persist and specific evidence-based practices—such as multi-systemic therapy, cognitive behavior therapy, assertive community treatment (ACT), illness self-management and recovery, and supported housing and employment—are slow to be adopted, despite their proven superiority. A national strategy must ensure a concerted effort by states and localities, health plans, provider organizations, specialists, consumers and others to address improvements in mental health care quality.

### *Patient-Centered Outcomes Research*

The bill seeks to ensure the quality of health care by establishing a private, non-profit corporation known as the Patient-Centered Outcomes Research Institute. The Institute would establish national priorities for comparative effectiveness research and conduct, support and synthesize results from comparative clinical effectiveness research with respect to quality, appropriateness and effectiveness of services. The Institute would also be charged with disseminating research findings to patients, clinicians and the public to help inform health care decisions.

A recent report issued by the Institute of Medicine (IOM) listed a number of behavioral health disorders and treatments among its top 100 priorities for a new national investment in comparative effectiveness research. Although many evidence-based, effective treatments exist for mental health and substance use disorders, therapies that are less or not effective continue to be used in a variety of treatment settings; fewer than 25% of individuals with serious mental illness receive appropriate care. A systematic review of data regarding mental health and substance use disorder treatments will inform and encourage improvements in practice and prevention efforts.

### *Community Health Teams*

The Senate bill encourages the patient-centered medical home concept by providing grants for the development of Community Health Teams by qualified providers and entities. Community Health Teams are designed to support the development of an integrated team of providers that provide coordinated and integrated services and are provide comprehensive management and coordination of an individual's care. Teams may include primary care providers, specialists, including mental health providers, other clinicians and licensed integrative health professionals.

These teams are patient-centered and holistic and include community programs and approaches to promote wellness and healthy lifestyles.

### **Voluntary Insurance for Home and Community-Based Living Assistance**

The bill establishes a national voluntary insurance program known as the CLASS (Community Living Assistance Service and Supports) Independence Benefit Plan, to pay for long-term care, including home-based services. For many individuals with mental illnesses, long-term services and supports are a vitally important and often unmet care need. The provision aims to provide individuals with functional limitations, such as those with psychiatric disabilities, means to maintain independence in their communities through financing strategies and infrastructure development. The program will be implemented by the Secretary of Health and Human Services who will determine the details regarding eligibility criteria and benefit levels.

This provision addresses a big gap in coverage for people who develop functional impairments due to physical or mental health conditions, allowing them to remain in their home. It is designed to change reimbursement policies that favor institutional care over home-based care.

Many people with mental illnesses who are currently in nursing homes or residential care facilities do not need to be there and would function better if supported in the community. The cost-savings are potentially dramatic. For example, the cost of housing and assertive community treatment for a person with a serious mental illness in New York City is roughly \$22,000, while a community residential facility is about \$65,000.

### **Modernizing Disease Prevention of Public Health Systems**

The bill aims to promote access to preventive health and wellness services for all Americans, regardless of age, gender, ethnicity, or physical or cognitive ability.

#### *National Prevention, Health Promotion and Public Health Council and Strategy*

The Senate bill establishes a National Prevention, Health Promotion and Public Health Council to provide leadership and coordination of prevention, wellness, and health promotion practices and to develop a National Prevention and Health Promotion Strategy. This strategy would contain specific priorities and goals aimed at the improvement and promotion of the nation's health and reduction of the incidence of preventable illness and disability, such as mental illnesses. In order to facilitate the implementation of a national strategy, the bill creates a Prevention and Public Health Investment Fund to expand and sustain prevention and public health programs and contain the rate of growth in public and private health care costs.

#### *Prevention Task Forces and Education*

The Senate bill establishes two separate, collaborative task forces to promote public health and prevention strategies. The Preventive Services Task Force would focus on clinical preventive

services with a population-based, public health approach. This Task Force would review the scientific evidence concerning preventive services and develop and update recommendations for the health care community. It would also identify gaps in research and develop additional topic areas for review, disseminate recommendations, and provide technical assistance to the health care community.

The bill also creates a Community Preventive Services Task Force to examine evidence regarding community-based prevention interventions and develop a guide for clinicians and organizations who deliver population-based services. This Task Force would be charged with collaborating with the Preventive Services Task Force.

In order to ensure that Americans have access to accurate information about individual prevention strategies and are encouraged to engage in healthy preventive behaviors, the Senate bill calls for the development of a national public–private partnership to implement a prevention and health promotion outreach and education campaign. This partnership would raise public awareness of the benefits of prevention and health improvement across the life span, using mixed-media and the internet to achieve this goal.

Creating an effective national public health-based prevention strategy will substantially benefit individuals with mental illness. Prevention and early identification of both health and mental health problems allows for early intervention which can effectively reduce the burden of disease on individuals, their families and communities. Mental health promotion based in the community is fundamental to overall prevention and wellness strategies. Promoting research on evidence-based prevention strategies and encouraging a recognition of the benefits of prevention will foster the development of successful strategies across the country. For example, public outreach and education about mental illnesses could reduce stigma, inform individuals of treatment options, and encourage more people to access critical treatment services.

#### *National Centers for Excellence for Depression*

The amended bill contains a provision championed by Senator Debbie Stabenow that instructs the Secretary to provide 5 year grants to entities or organizations for the establishment of depression centers of excellence. Such centers would aim to increase access to the most appropriate, interdisciplinary and evidence-based care for individuals with depressive disorders, as well as translate to practice and disseminate academic research, develop and improve treatment standards and guidelines, and foster communication with other providers attending to co-occurring physical health conditions. A National Coordinating Center would also be established to coordinate the network of centers of excellence once established.



## **Increasing Access to Clinical Preventive Services**

The Senate bill would increase access to essential services necessary to promote prevention and good health. To promote access in underserved communities and for underserved populations, it would create:

- Grants for school-based health clinics, with preference given to areas that have shortages of primary care and mental health services for children and adolescents. The core services of these school-based clinics include comprehensive primary health services, including mental health services and referrals. Children spend a significant portion of their day at school, making schools ideal places to locate necessary mental health services, allow for collaboration between schools and local mental health agencies, and link children with appropriate services within the community.
- The Community Transformation Grant Program, which will provide grants to states and localities and national networks of community-based organizations for the implementation, evaluation, and dissemination of proven evidence-based community preventive health activities.
- Healthy Aging, Living Well Grants to state and local health departments for five-year pilot programs that provide public health community interventions, screenings, and, where necessary, clinical referrals for individuals who are between 55 and 64 years of age.
- Individualized Wellness Plan Demonstrations to test the impact of providing populations at-risk who utilize community health centers with an individualized wellness plan that is designed to reduce risk factors for preventable conditions identified by a comprehensive risk-factor assessment.

Community-based prevention strategies and wellness promotion programs that assist people with chronic diseases would be beneficial for individuals with mental illnesses as they are at greater risk than others for chronic health conditions such as heart disease and diabetes.

## **Workplace Wellness**

The bill contains provisions that would encourage employees to participate in employer-sponsored wellness programs by providing participating employees with premium discounts, rebates, or other rewards. Although the goal of increased wellness is laudable, provisions that allow significant variation in premium rates based upon participation in wellness programs are of concern. People with chronic diseases, mental illnesses, or disabilities may be unable to meet wellness goals for reasons related to their illness or disability. Additionally, low-income Americans, many of whom suffer from mental health disorders, may be disadvantaged by wellness programs as they are at greater risk for the health conditions wellness programs target, and barriers to healthy living, such as a lack of affordable healthy foods and safe

exercise spaces in low-income neighborhoods, can make program participation simply unfeasible.

### **Support for Prevention and Public Health Information**

The bill would encourage public health research activities focused upon prevention, including funding for research on evidence-based practices relating to prevention, translating research to practice, enhanced disease surveillance, identifying effective strategies for coordinating public health services in community settings and studying the public health workforce. Data on specific socioeconomic factors, including disability status, will be required to detect and monitor trends in health disparities.

Research on prevention is critical to determine the best prevention and early intervention strategies for mental disorders, as well as funding dedicated to exploring and promoting innovative, effective mental illness prevention practices. Data on disabilities, including mental health-related disability, is rarely collected in national health studies, preventing accurate assessment of health disparities for individuals with disabilities.

### **Health Care Workforce**

The bill would improve access to health services through the planning and implementation of strategies to address capacity issues and gaps in the workforce. These strategies include tuition reimbursement and other incentives for medical students, nursing students, pediatric specialists (including qualified child and adolescent psychiatrists, psychologists, social workers, and other behavioral health providers), public health professionals, and allied health professionals. The bill would also provide funding to increase capacity in primary care.

Mental health care, like physical health care, is experiencing a workforce crisis that must be addressed to ensure continued access to vital treatment and rehabilitative services. The Health Resources and Services Administration Shortage Designation Branch reports that as of March 31, 2009, there are more than 3,000 communities or areas experiencing shortages in mental health practitioners that affect over 80 million individuals.

New mental health and behavioral health education and training grants would support:

- the recruitment, education, and clinical experience of students in social work programs;
- the development and implementation of interdisciplinary training of students in psychology to foster provision of mental health services;
- internships or field placement programs in child and adolescent mental health in specified fields; and
- training of paraprofessional child and adolescent mental health workers.

Grants would also be awarded to promote the use of community health workers in vulnerable communities and for other initiatives, like perinatal home visits for the promotion of maternal and child health.

A primary care extension program would be established to support and educate primary care providers about evidence-based practices, prevention and health promotion services, chronic disease management and mental health. Primary care providers would collaborate with community-based “Health Extension Agents” to implement patient-centered medical homes and other collaborative care activities.